**PEDIATRIC UROLOGY OF WESTERN NEW YORK, P.C.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed a copy of Pediatric Urology of WNY, PC Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Date of Birth Signature of Parent Date

Person(s) to contact regarding appointment/medical information

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Mom( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Dad( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (relationship)

**Appointment Information Medical information**

Home phone (including auto call)? □ Home phone (including auto call)? □

Cell phone (including auto call)? □ Cell phone (including auto call)? □

Mobile text (including auto call)? □ Mobile text (including auto call)? □

Work phone? (listed above) □ Work phone? (listed above) □

With another person, if so who? (below) □ With another person, if so who? (below) □

Send via mail? □ Send via mail? □

Send via email/portal? □ Send via email/portal? □

If we are unable to reach the people listed above, please provide us with someone else we can contact.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave them a message yes

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave them a message yes

***We are unable to provide medical/appointment information to people not listed and authorized by you.***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Reviewed HIPAA Privacy Statement Signature of Patient or Personal Representative

**\*\*\*Fill out the top portion and we will obtain your signature at your appointment.**